PRELIMINARY

HB 4018 -2, -4, -6, -9, -10, -11, -12, -14, -15, -16, -17 STAFF MEASURE SUMMARY

House Committee On Health Care

Prepared By: Oliver Droppers, LPRO Analyst
Meeting Dates: 2/7, 2/9, 2/12

WHAT THE MEASURE DOES:

Modifies requirements for coordinated care organizations (CCOs). Requires governing body of CCOs be subject to public meeting laws. Allows Oregon Health Authority (OHA) to contract with a statewide CCO. Specifies CCOs spend earnings above specified threshold on services designed to address health disparities and social determinants of health. Modifies composition of a CCO's governing body. Declares an emergency, effective on passage.

ISSUES DISCUSSED:

Proposed amendments.

EFFECT OF AMENDMENT:

-2

Establishes a fund to be managed directly by the agency for the management of restricted reserves. Requires transfer of restricted reserves on a per capita basis to the CCO to which a member is transferred upon termination of a contract and after claims and liabilities are paid. If a member remains on fee-for-service after a contract is terminated, then the OHA shall retain monies in the fund to bear the risk of that member. administration of the Medicaid program.

-4 Requires actionable, measurable, and specific outcomes be embedded in the strategic business plan of each CCO and requires the development of a CCO-wide equity plan be adopted by January 1, 2020 to meet those goals.

-6 Requires certain financial information including investments and payments made to partner organizations be collected and published on OHA's website. Requires information about formal meetings of governance and community councils be posted on the OHA's website.

-9 Requires OHA to collaborate with CCOs to develop a plan to fully implement alternative payment methodologies by December 31, 2023.

-10 Requires CCOs to report annually to OHA financial information including profit margin, medical and nonmedical costs, investment and payments made to partner organizations.

-11 Requires OHA to modify billing requirements related to mental and behavioral health services.

-12 Allow OHA to contract with a single statewide CCO.

-14 Codifies in statute existing contract provisions for notice of nonrenewal. Allows at least two-weeks review of final contract terms as submitted to the Centers for Medicare and Medicaid Services (CMS) – prior to the notice of nonrenewal. Establishes a notice of nonrenewal that is 120-days from the end of the current benefit year. Requires, upon notice of nonrenewal, that CCOs develop a transition plan to be approved by OHA and requires at least 90-days' notice for members and providers in the manner developed and approved by the Authority. Director retains the ability to waive or reduce the notice periods if waiver of the periods do not result in the inefficient and ineffective administration of the Medicaid program.

-15 Requires OHA to work with CCOs to develop a plan to move from a predominantly fee-for-service payment methodology for provider reimbursement in accordance with the state's federal 1115 waiver and the Centers for Medicare and Medicaid Services (CMS). The amendment requires full implementation by December 31, 2024.

-16 Establishes a health equity metrics subcommittee within the Health Plan Quality Metrics Committee. Tasks subcommittee with the development of health outcome and quality measures that identify disparities in access to and the availability of effective and culturally appropriate health care for members of CCOs who may experience racial or ethnic disparities. Subcommittee must create a set of health outcomes and measures no later than December 31, 2018. The metric or metrics approved by the Health
Plan Quality Metrics Committee must be adopted into CCO contracts no later than January 1, 2020.

-17 Defines social determinants of health. Requires OHA to collaborate with CCOS to develop requirements for CCOs to invest in social determinants. Requires a CCO to spend one percent of its global budget on investment in social determinants of health.

BACKGROUND:

Oregon's 15 coordinated care organizations (CCOs) are organizations governed by health care providers, community members, and organizations responsible for the financial risks. CCOs offer patient-centered health care delivery. CCOs are responsible for the integration and coordination of physical, mental, behavioral, and dental care services for 90 percent of Medicaid beneficiaries enrolled in the Oregon Health Plan (OHP). All 15 CCOs operate within a global budget, which grows at a fixed rate, achieve performance goals, and are held accountable for the Triple Aim. The Triple Aim seeks to improve the individual experience of care, improve the health of populations, and reduce the per-capita costs of care for populations.

In 2012, the Oregon Health Authority (OHA) executed five-year contracts with CCOs in conjunction with a Section 1115 federal Medicaid waiver. The contracts require each CCO to have a comprehensive plan that describes their goals and activities for transforming care, a written plan for using health information technology, and to implement quality improvement plans. The contracts will be renewed in 2019 for the next five-year period (2020-2025).

In 2016 the Oregon Health Policy Board (OHPB) received a request to provide independent policy guidance to the Legislative Assembly and the OHA regarding the future of CCOs in Oregon's health care system. To accomplish this request, the OHPB conducted a qualitative and quantitative analysis and developed a set of recommendations to inform the next phase of Oregon's CCO model (CCO 2.0). The 2017 recommendations include:

- improving fiscal transparency,
- strengthening accountability,
- advancement of OHA monitoring and oversight of CCOs,
- enhancing community access and input to CCOs,
- increasing focus on social determinants of health, and
- supporting sustainable costs in Medicaid.

In 2017, the Center for Health Systems Effectiveness released a comprehensive evaluation of Oregon's 2012-2017 Medicaid waiver including an assessment of the CCOs. Findings indicate that CCOs were successful with decreased spending, investing in infrastructure for health care transformation, and improvements in overall quality and access to care.